Name: ___________________________  Unit: _____

Profession:  □ RN  □ RPN  □ PT  □ OT  □ SW  □ Other ____

Note: Each question has only one correct answer.

1. If a patient is identified as being at high risk for developing delirium, his/her mental status should be assessed and documented:
   a. at least once every 24 hours
   b. twice a day for 48 hours
   c. at least once every 8 hours for 48 hours
   d. on admission or whenever the nurse notices a change in mental status

2. An elderly patient has an acute onset of delirium, an elevated temperature, a history of UTIs and a recent fall at home. The most likely cause is:
   a. drug toxicity
   b. respiratory infection
   c. UTI
   d. GI problems

3. The following factors increase the risk of delirium:
   a. age 85 or older
   b. dementia
   c. poor functional status
   d. all of the above

4. A good strategy for preventing delirium in elderly hospitalized patients is:
   a. using restraints at night to make sure they remain rested and in bed
   b. making sure they walk or engage in range-of-motion exercises 3 times a day
   c. limiting their fluid intake during the latter part of the day
   d. making sure sedatives and antianxiety agents are prescribed for them

5. A strategy for keeping elderly patients with delirium or dementia, or both, comfortable and oriented is:
   a. keeping the lights on at night to prevent falls
   b. changing their room placement periodically to remind them that they are not at home
   c. keeping caregiver assignments as consistent as possible
   d. minimizing family visits to prevent disorientation about their whereabouts

6. A hospitalized elder with delirium tells you that a man is threatening her and will not leave. There is no one in the room but you and her. What is the best approach?
   a. Telling her that there is no threatening man in the room.
   b. Reminding her that her medical condition will sometimes make her see things that aren’t there
   c. Bringing several other staff members into the room to assure her that there is no threatening man in her room
   d. Respond to the patient’s fear and reassure her that you will keep her safe

The Ottawa Hospital, 2007
7. A key factor in differentiating delirium from depression and dementia is to consider the patient’s:
   a. mood
   b. sleep pattern
   c. psychomotor activity
   d. rapidity of onset of symptoms

8. Using the Confusion Assessment Method (CAM), the diagnosis of delirium is likely in a patient who demonstrates:
   a. an acute onset, a fluctuating course, normal attention, disorganized thinking, and an altered level of consciousness
   b. an acute onset, a steady course, inattention, disorganized thinking, and an altered level of consciousness
   c. an acute onset, a fluctuating course, inattention, disorganized thinking and alertness
   d. an acute onset, a fluctuating course, inattention, disorganized thinking, and an altered level of consciousness

9. When assessing elderly patients for delirium, drug toxicity or an adverse drug reaction is most likely when the patient:
   a. is taking a short course of antibiotics
   b. takes 5 or more medications
   c. has a history of constipation
   d. takes supplemental thyroid hormone

10. A helpful technique for communicating with patients with delirium is to:
    a. speak gently & make all instructions as simple as possible
    b. avoid eye contact, because they may perceive it as a threat
    c. re-orientate with papers and examples because they can be very agitated
    d. speak loudly and clearly

11. Planning care of a patient with delirium should include:
    a. removing calendars from the patient’s environment, because they can increase disorientation
    b. allowing family photos only if the patient can identify the people in them
    c. encouraging the patient to consistently use assistive devices like eyeglasses and hearing aids
    d. maximizing the patient’s exposure to environmental sounds, such as alarms, to remind the patient that he or she is in the hospital and not at home

12. A helpful intervention for a patient with delirium and pain is to:
    a. administer scheduled or “around the clock” medications, rather than intermittent doses
    b. wake the patient often to offer PRN medications
    c. encourage the patient to tell you every time he/she is experiencing pain & to ring the bell
    d. place the patient’s mattress on the floor

13. When a patient has been screened and identified with a possible delirium you can:
    a. place the CAM Risk Factor Alert on the chart
    b. place pre-printed physician’s orders on the chart for review
    c. target interventions to the underlying root causes
    d. teach patient and family using the patient teaching handout
    e. all of the above
### Answers to Delirium Quiz

**Review Self-Directed Resource Guide for Delirium**

*LOOK, SCREEN & INTERVENE*

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Quiz Answers with Rationales.

1. Chapter 3, page 10; Chapter 6, page 27  
   d. The Policy & Procedure states that a patient’s mental status should be assessed on 
admission and whenever a change is noticed. Knowing a patient’s baseline cognitive 
status is key to recognizing that a change has occurred.

2. Chapter 3, page 10  
   c. A UTI is often asymptomatic except for a new onset of falls and delirium.

3. Chapter 3, page 10  
   d. Advanced age, pre-existing cognitive deficits and poor functional status have all 
been found to be factors associated with the development of delirium.

4. Chapter 5, page 23  
   b. Encouraging mobility helps to improve strength and prevent the deconditioning and 
other complications which may contribute to the development of delirium.

5. Chapter 5, pages 23  
   c. Consistency in the caregiver benefits the patient whose short term memory may be 
affected; it also helps the staff get to know the patient better. In addition, it promotes 
the setting of a consistent care routine which has been shown to decrease anxiety.

6. Chapter 2, page 7  
   d. Hallucinations may be very real to delirious patients; reassurance that they will be 
safe may be the best intervention during the acute phase.

7. Chapter 2, page 6; Chapter 6, page 31  
   d. A key difference in determining that a patient is delirious is the abrupt onset of 
symptoms (from hours to days). Dementia and depression tend to have a more gradual 
onset.

8. Chapter 2, page 7; Chapter 4, page 18; Chapter 6, page 27  
   d. As per the Confusion Assessment Method, for a delirium to exist, the patient must 
demonstrate both an acute onset, inattention, and either / or disorganized thinking or 
an altered level of consciousness.
9. **Chapter 3, page 11**  
   *b.* Evidence suggests that drug toxicity and adverse drug reactions are more likely to occur when an older patient is taking 5 or more medications.

10. **Chapter 5, pages 23 - 24**  
    *a.* Keep instructions simple by only asking for one thing at a time. Delirious patients may not be able to remember multiple instructions.

11. **Chapter 5, pages 23 - 24**  
    *c.* Sensory deprivation will contribute to delirium. Patients may misinterpret sensory stimuli in the environment if they cannot see or hear. Evidence supports ensuring the patient uses all assistive devices such as glasses and hearing aids or amplifiers.

12. **Chapter 5, pages 23 - 24**  
    *a.* Research has shown that around the clock analgesia is more effective than PRN by maintaining a steady blood level.

13. **Chapter 6, page 26 - 28**  
    *e.* All elements are part of the Policy & Procedure, intended as ways to enhance care of the delirious patient. Clinical units may choose whether or not to use the Pre-Printed orders based on their particular needs. Consistency is essential in communicating delirium risk, symptoms, interventions and their effectiveness.